*Life Change Psychotherapy Institute*

## Patient Information

**First Name:** _____ **MI:** ____

**Last Name:** _____

**Address:** _____

**City:** _____ **St.:** ____ **Zip:** _____

**Home Phone:** (  )  -

**Business Phone:** (  )  -

**Cell Phone:** (  )  -

**Birth Date:** /  /

**Gender:** _____

**E-Mail**_____

By providing my email, I agree to receive emails from Life Change Psychotherapy for informational purposes. I also understand I may unsubscribe at any time.

## General Information

**Marital Status:**

☐ Single

☐ Married

**Where did you hear about us?**

_____

May we contact this individual to thank them for the referral?

Yes ☐ No ☐

**Who to call in Emergency:**

First Name: _____ Relationship _____

Last Name: _____

Phone Number: (  )  -

## Insurance Company Information

Ins. Co. Name: _____

Address: _____

City: _____ St: ____ Zip: _____

Insurance ID Number: _____

Policy Holder

First Name: _____ MI: ____

Last Name: _____

Address: _____

City: _____ St: ____ Zip: _____

What is your relationship to the insured? ☐ Self ☐ Spouse ☐ Child ☐ Other ☐

Employer's Name: _____

Policy Holder's Date of Birth: /  /

## Medical Information

Name of Doctor: _____

Phone Number: (  )  -

Name of Psychiatrist: _____

Phone Number: (  )  -

**Medications**

| Name: | Dosage: | Start Date: | For Treatment of : |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Use reverse side for additional information**

☐ Please list any known allergies: _____